PATIENT INFORMATION SHEET

DATE __________________

PLEASE PRINT CLEARLY

PATIENT NAME _____________________________ DATE OF BIRTH__________AGE_____SEX___

MARITAL STATUS____________SOCIAL SECURITY NO._________________________________

ADDRESS____

CITY_______________________STATE_________________ZIP__________________

PHONE___________________EMAIL : ____

REFERRING DOCTOR___________________________________
____

EMPLOYER____PHONE_________________________

ADDRESS______________________________________CITY___________STATE___ZIP_________

SPOUSE (OR PARENT OF MINOR)_________________________DATE OF BIRTH: _____________

SOCIAL SECURITY NO: _______________________________________

SPOUSE'S EMPLOYER_______________________________________PHONE___________________

PERSON TO CONTACT IN CASE OF EMERGENCY_____________________PHONE_____________
____

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST:

IF YOUR VISIT IS A WORKMAN'S COMP CLAIM PLEASE GIVE THE FOLLOWING INFORMATION

INSURANCE CARRIER NAME ____ PHONE ________________

EMPLOYER AT TIME OF INJURY ______________________________________ PHONE ________________

DATE OF INJURY ___________________ REPORTED TO _____________________________

CLAIM NUMBER ______________________________ CASE MANAGER ______________________________

Payment is expected at the time service is rendered if there is no insurance to file. We will file insurance for patients who have coverage.

I authorize Georgia Regional Urology, P.C./David L. Perlow, M.D. to release any and all information regarding diagnosis, treatment, and prognosis with respect to any physical condition and/or treatment of me to my insurance company or its legal representative. Any such disclosure shall be limited to information that is reasonable and necessary for the discharge of the legal or contractual obligations of the insurance company. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

I understand that the information obtained by use of this authorization will be used by my insurance company to determine eligibility for benefits under an existing policy. Any information obtained may only be released by my insurance company to any other person or organization as governed by HIPAA or unless I so authorize.

I also authorize payment of all medical benefits to be made payable to David L. Perlow, M.D./Georgia Regional Urology, P.C.

I give my permission to be examined and treated by David L. Perlow, M.D.

X____ ____________________

Signature of Patient or Parent of Minor (**REQUIRED SIGNATURE**) Date

IF YOU WISH FOR OUR OFFICE TO DISCLOSE HEALTH INFORMATION TO A FAMILY MEMBER PLEASE INDICATE BELOW:

PERMISSION TO DISCLOSE INFORMATION TO THE FOLLOWING:

NAME _____________________________________

ADDRESS ____PHONE _____________

SPECIFIC INFORMATION TO BE DISCLOSED:

[ ] ALL RECORDS [ ] OTHER EXPLAIN: ______________________________________

SIGNATURE OF PATIENT: ____

I have received a copy of Georgia Regional Urology, P.C.'s/Perlow Facility, LLC's Notice of Privacy Practices And Ownership of Practice and Expertise of Physician, Patients Rights and Responsibilities, DNR Policy, Information Regarding the Frievance Procedure and Information Regarding Our Billing Practice.

X____ ______________________

Signature of Patient or Guardian (**REQUIRED SIGNATURE**) Date